EDITORIAL

Mandated Reporting of Perinatal Substance Use
The Root of Inequity

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Related article

On April 15, 2021, "The Daily Show" host Trevor Noah posted a video on police brutality and posed the question, "Where are the good apples?"[1] Referencing police murders of unarmed Black men, he states, "We're told time and time again that these incidents we keep experiencing are because of bad apples…but where are the good apples? Where are the cops who are stopping the cop from putting his knee on that neck?"[1] He ends with a compelling, and chilling claim: "We're not dealing with bad apples…we're dealing with a rotten tree that happens to grow good apples, but for the most part the tree that was planted is bearing the fruit that it was intended to."[1] There are days when I cannot help but ask myself if, as a physician, I too am just a good apple hanging from a rotten tree. Then there are darker days when I have to wonder, "Am I even a good apple?"

In her 2020 article, Perritt[2] brings this "good apple" question into focus by indicting health care professionals, particularly obstetricians and gynecologists (OBGYNs), for funneling women into the criminal legal and child welfare systems. This important study by Austin and colleagues[3] hits right at the heart of this matter, as the authors explore mandatory prenatal substance use reporting policies, which serve as the principal funneling mechanism, and their impact on prenatal and postnatal care utilization.

Mandatory reporting policies are the primary means by which health care professionals are conscripted into criminalizing patients. These policies deputize health care professionals as agents of the state, compelled to inform child protective services (CPS) of suspicion of child abuse, harm, or neglect. While the call to protect children and advocate for their welfare seems noble, in practice, this reporting is often deployed in a racially biased and paternalistic manner having less to do with child harm and more to do with judgment and punishment of patients deemed unfit for parenthood.[4] It increases the likelihood of separating children from their families at the time of delivery and ushers families into a system of state surveillance. This cascade of surveillance and punishment has the most profound impact on low-income individuals, marginalized individuals, and racially and ethnically minoritized individuals and fosters a system designed to penalize parents, particularly mothers, rather than improve the systems of inequity that render them vulnerable to neglect and harm.

Fearing that the introduction of surveillance and punishment into the physician-patient relationship might deter patients from seeking medical care and services, mandatory reporting has been discouraged and denounced by leading medical and public health associations. In fact, Austin et al[3] find that pregnant women who reported substance use and deliver in states with a child abuse and/or mandated reporting policy are less likely to receive timely prenatal care, adequate prenatal care, and postpartum care compared with women in states that have neither policy.[3] Care delays may have marked implications for access to substance use disorder treatment and services for pregnant patients and implications for neonatal abstinence syndrome, low birth weight, prematurity, and other neonatal birth outcomes.

While the opioid epidemic has disproportionately affected the White community,[5] reporting mandates and punitive policies for substance use disorder disproportionately affect Black communities. Among their findings, Austin et al[3] note that there was a higher percentage of births to Black women in states with child abuse policies and/or mandated reporting policies.[6] This raises concerns regarding the study's equity implications. Although rates of perinatal substance use are similar among Black and White women, Black as well as Indigenous women are more likely to be screened for illicit substance use in prenatal care.[7] This frequently occurs without their knowledge or permission and has resulted in parents losing their parental rights and being incarcerated. In addition to being more likely to be drug tested, Black women are also more likely to be reported to CPS.[7] To provide context for these inequities, it is helpful to understand the historical backdrop that gives rise to biases against Black women related to substance use and their fitness to parent.

A Legacy of Harm and Dehumanization

Substance use reporting mandates became popularized in the 1980s and 1990s amid a war on crime, wherein Black women became targets for punishment, depicted as delivering "crack babies" who would grow up to become "super predators."[2] These deleterious tropes, discriminatory reporting, and disparate punitive actions were rooted in a particularly anti-Black racist form of misogyny, termed *misogynoir*.[8] Adopted in 1662, the legal doctrine of *partis sequitur ventrum* legally dictated that the legal status of a child would follow that of their mother. This strategic departure from patrilineal tradition ensured that children born to enslaved women would also be enslaved. At this critical juncture, state-sanctioned violence against Black women's bodies became codified, and the commodification, exploitation, and control of Black women's reproduction became a central driver of the nation's capital gains.[9,10] Misogynoir was born of this history of exploitation

and denigration of Black women's bodies and often manifests as dehumanizing depictions to justify their exploitation.[8] Black women are cast as lazy, even though they have forever been subjected to physical labor. They are cast as hypersexual, even though they were forcibly impregnated by enslavers and bred for profit. They are cast as unfit mothers, even as they were forced to rear and nurse generations of White children while a system of inequity and impoverishment undermined their ability to parent their own children in safe, well-resourced environments.

Present-Day Harm and Inequity

At present, misogynoir is the root of many judgments and assumptions derived from dehumanizing stereotypes and tropes that disadvantage Black women in clinical care and lead health care professionals to question their fitness to parent.[11] These judgments drive greater suspicion, scrutiny, and drug testing of Black women and result in disparate social work consultations and CPS referrals.[11,12] Health care professionals have been trained to conceive of CPS as a good. It is not to say that the intentions of most in the CPS arena are not pure, but similar to the good apple analogy in the criminal legal system, our nation's child welfare system has roots in anti-Black racist ideologies, policies, and practices.[4]

Black families have been dismantled and dismembered for profit since enslaved Africans were brought to the US—the auction block creating a societal norm and acceptance of separating Black families. This legacy persists in the uneven handling of child welfare cases for Black families still today. Black children make up 42% of the half million children who are taken from their homes each year.[4] Although most Black children are removed for poverty-related neglect, studies of substance use in pregnancy have found that Black women are 10-fold more likely to be reported to CPS and as much as 72% more likely to have their child removed from their care after testing positive for substance use compared with White mothers.[4] Once in foster care, Black children remain in the system longer than White children, are less likely to be adopted or be reunified with their parents, and generally receive inferior services.[2,4,13]

A Perfect Storm

If we were to identify a triumvirate of racial inequity, alongside the criminal legal system and child welfare systems stands the US health care system, which delivers astoundingly disparate results in almost every arena of care, including adverse maternal-child outcomes. Black infant mortality rates more than double that of White infants,[14] and Black women's maternal mortality is 3-fold to 4-fold greater than White women.[15] A growing body of literature contributes obstetrical racism and violence to these inequities, atop inequities that disproportionately weather Black women such that they enter pregnancies with greater comorbidities.[16]

This triumvirate, each exhibiting this interplay of interpersonal bias layered atop structured inequity, cumulatively converges in maternity care and mandated child abuse reporting for prenatal substance use. This further indicts the health care system, which, under state-mandated requirements, is complicit in deterring the very populations at greatest risk of adverse pregnancy outcomes from receipt of care. The sad irony is that child welfare systems disproportionately target, impugn, and penalize Black families for the conditions of poverty, trauma, and neglect that were foisted on them through centuries of structured systemic racism, neglect, and harm.

So, I return to the question, "Am I even a good apple?" Even as a Black physician, I recognize that white supremacy is so embedded in institutional policies and practices that it is seemingly impossible to do no harm. However, these very policies conscript physicians to enact harm, ultimately undermining the physician-patient relationship and exacerbating inequities in patient care and outcomes. Instead of mandating reporting, policy efforts should focus on ensuring more equitable educational opportunities, expanding access to treatment for pregnant and parenting women, creating affordable housing, expanding parental leave, ensuring living wages, promoting universal health care, and increasing access to mental health care. These are the types of policies that would protect children from neglect and abuse. As evidenced by the study by Austin et al,[3] policies driving fear, blame, and punishment appear to be drivers of greater child harm, not greater child protection.

ARTICLE INFORMATION

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